Direct Support Provider Paid Sick Leave

<table>
<tr><td colspan="2">Employee Name:</td><td colspan="2">Supervisor/Coordinator Name:</td></tr>
<tr><td>Client Name:</td><td colspan="2">Does your client need a fill in provider during your time off?

☐ Yes ☐ No</td><td>Service Being Provided:</td></tr>
<tr><td colspan="4">Leave Details:
(optional)</td></tr>
<tr><td>Start Date:</td><td colspan="2">Start Time:
☐ AM
☐ PM</td><td rowspan="2">Total number of hours or days (8 hours max/day) being requested:</td></tr>
<tr><td>End Date:</td><td colspan="2">End Time:
☐ AM
☐ PM</td></tr>
<tr><td colspan="4">*If paid sick time is used three (3) or more consecutive work days, a doctor’s note or other documentation is required in order to return to work.</td></tr>
</table>

Signature: _____

Date: _____

Email: _____

Phone Number: _____